SOCIAL MOBILITY AND MENTAL ILLNESS[1, 2]

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This is a further report on the interdisciplinary research into social stratification and psychiatric disorders that has been underway in the New Haven community for the past 5 years. Previous papers have reported highly significant relationships between social class position and (1) the number of patients in treatment; (2) the types of disorders; and (3) the kinds of treatment received(5, 6, 7, 12, 13, 14, 17).

A basic hypothesis of this research postulated interrelationships between mobility in the class structure and mental illness. The idea that an individual's movement in the social structure is associated with the development of psychiatric difficulties has been expressed by both psychiatrists(4, 8, 11, 15, 16) and sociologists(10, 18, 19). Some empirical research has been done on the question in each field, but psychiatrists and sociologists have not worked together previously to determine if psychiatric patients are more or less mobile socially than a comparable group of nonpatients. The research reported here attempts to do this.

One of our general propositions under study hypothesized that in the several social classes interrelationships exist between mobility factors and diagnosed psychoneurosis and schizophrenia. Because of space limitations only 2 aspects of mobility, out of a much larger matrix that was used to test relevant facets of this proposition, will be reported here. They are: (1) achieved social mobility, and (2) discrepancies between an individual's achievement and his aspirations. A specific proposition on each factor was stated as follows: (1) There is a differential relationship between the amount of social mobility achieved by nonpatients in comparison with psychoneurotics and schizophrenics of the same class as the nonpatients. (2) A significant discrepancy exists between a psychoneurotic's or schizophrenic's achieved mobility and aspired mobility.

RESEARCH DESIGN

This research was designed so that class position, on the one hand, and the presence or absence of diagnosed mental illness, on the other, could be controlled. It was reasoned that by holding each of these factors constant, the assumed interrelationships between social mobility and mental illness could be found. To achieve this objective, samples of psychoneurotic and schizophrenic patients in classes III and V were drawn from the psychiatric population of the New Haven community. Comparable control samples of nonpatients from classes III and V were drawn from the general population.

The samples were selected from nonadjacent classes because we believed that the influence of class factors could be determined more easily in persons from distinctly different classes than in persons from adjacent classes. Classes III and V were selected for the following reasons: (1) These classes have sharply different prevalence rates for treated schizophrenia and psychoneurosis; (2) they have not been studied carefully in previous psychiatric research; and (3) they comprise approximately 40% of the population of the New Haven community.

Each class may be characterized briefly as follows: Class III is composed of proprietors of small businesses, white-collar workers, and skilled manual workers, who are, for the most part, high school graduates. These people live in apartments and single-family dwellings in widely scattered residential areas. Class V is composed almost exclusively of unskilled and semiskilled workers who typically have an elementary education or less and who live in the most crowded slum areas of the city.

The combination of patients from 2 different diagnostic categories and 2 social classes, with nonpatients from the same classes, pro-

[1] Read at the 110th annual meeting of The American Psychiatric Association, St. Louis, Mo., May 3-7, 1954.

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TABLE 1

NUMBER OF PATIENTS AND NONPATIENTS STUDIED BY CLASS

Social Classes	Patients		Nonpatients (Controls)
	Neurotics	Schizophrenics	
III	13	13	30
V	12	12	30
Total	25	25	60

duced the 6-cell research design presented in Table 1.

A glance at Table 1 will show that each of the 4 cells for patients is filled with a minimum of 12 cases; each cell for nonpatients is populated with 30 individuals.

All individuals in the study, patients and nonpatients, are white and between the ages of 22 and 44. These age limits were imposed because attention was focused upon patients who presumably had reached adult responsibility and adjustment, but who had not entered the involutional period. The ages of the nonpatients were held to the same limits so comparisons could be made between the 2 groups.

Detailed data were collected on each patient with an extensive schedule divided into 4 main parts. The first part was filled out by a psychiatrist in interviews with the patient; the second was filled out by a sociologist in an interview with members of the patient's family of orientation and his family of procreation. In addition, considerable material came from the clinical record and an additional clinical interview of the patient by a project psychiatrist. As a last step, the team developed 2 assessment schedules to evaluate the data systematically. While the data were being assembled on the patients, the sociologists interviewed the nonpatients with a different schedule.

The representatives of the samples of patients and nonpatients to their appropriate universes was crucial to the research. This was complicated by the differences in the way the 2 samples were obtained. Patients who met the requirements of the research design were selected individually. The nonpatients, on the other hand, were selected at random from the 5% systematic sample of the community's population used in earlier phases of the research. Representativeness of the nonpatients was determined by comparing them with the systematic sample of the general population on the following variables: age, sex, religion, ethnic origin, and class score. The patients were compared with the psychoneurotics and schizophrenics in the psychiatric population on the same variables. No significant difference was found at the 5% level of confidence on any variable when the 2 groups were compared with their parent universes. In short, the patients were representative of all psychiatric patients in their appropriate age, sex, class, and diagnostic groups, and the nonpatients were representative of the systematic sample of the New Haven community in their age, sex, and class groups. When the representativeness of the 2 samples was established, assumed interrelations between class position, mobility factors, and mental illness were tested.

Mobility was measured by the use of Hollingshead's 2-factor *Index of Social Position*. This Index is based upon education and occupation. The number of years of school the individual has completed is scored on an educational scale; likewise, his occupation is scored on an occupational scale. Then, the scale value for education is multiplied by a weight of 6, and the scale value for occupation by a weight of 8. The resulting calculated score is assumed to be an Index of the individual's position in the community's class structure.

Two Index scores were computed on each patient and nonpatient. The first was the score of the individual's parental family; the second was the score of the individual being studied. The score of the parental family was assumed to be the social base line of the individual in the study. The difference between the scores of the parental family and the individual in the study, whether positive or negative, was used as the measure of the individual's achieved social mobility. If the difference was positive, the individual was considered to be upwardly mobile; if negative, he was viewed as downwardly mobile.

When achieved social mobility had been defined, the crucial question was: Have the psychoneurotics or the schizophrenics in either class III or class V been more mobile or less mobile than the nonpatients? Answers to this question were sought by making a

series of comparisons of social mobility scores of the nonpatients with the patients. The t-test was relied upon in each comparison to determine significance of difference between the mobility scores of the control and the patient groups.

FINDINGS

Proposition I: Achieved Social Mobility in Class III.—Class III individuals, both patients and nonpatients, were far more mobile than class V individuals. This finding was in accord with the general assumption that class III represents one subcultural group, and class V a distinctly different one. As we expected, achieved social mobility in class III was almost entirely upward. Only 3 individuals were downwardly mobile by as many as 10 points; one was a nonpatient, one was a psychoneurotic, and one was a schizophrenic. All others were upwardly mobile by varying amounts. Three patients moved upward more than 50 points. All were females; one was a psychoneurotic; the others were schizophrenics.

The average amounts of mobility achieved by the nonpatients, the psychoneurotics, and the schizophrenics, in class III, are depicted in Fig. 1, which shows that in comparison with their parental families, the nonpatients moved upward 20 points, the psychoneurotics 27 points, and the schizophrenics 36 points on the *Index of Social Position.* The difference in achieved upward mobility between both the psychoneurotics and the nonpatients, and the schizophrenics and the nonpatients, is striking. The data indicate a definite interrelationship between social mobility and mental illness. The controls have been the least mobile, and the schizophrenics the most mobile of the 3 groups.

When the distinct relationship had been found between achieved social mobility and both psychoneurosis and schizophrenia, social mobility scores were computed on the patient's adult brothers and sisters to see if they had been as mobile as the patient. This operation showed that the psychoneurotic and schizophrenic patients in class III had been significantly more mobile than their siblings.

The next step in the analysis was to determine if the nonpatients, the psychoneurotics, and the schizophrenics had the same, or different, parental base lines. Components included in the base line were: (1) the *Index of Social Position* of the family of orientation; (2) ethnic origins, and the number of generations in the United States; (3) religious affiliation; and (4) community of origin. No significant differences were found on any of these factors when the nonpatients in class III were compared with the psychoneurotics and schizophrenics. Two conclusions were clear from these comparisons; first, that the 2 groups, nonpatients, psychoneurotics, and schizophrenics, had come from an essentially homogeneous social and cultural base; any differences that existed were of a random order; second, we infer the demonstrated differences in achieved social mobility in the present generation were produced by the differential efforts of the individuals in the study to attain more education and to get better jobs than their parents had had. In addition, the inference may be made that the psychoneurotics, and especially the

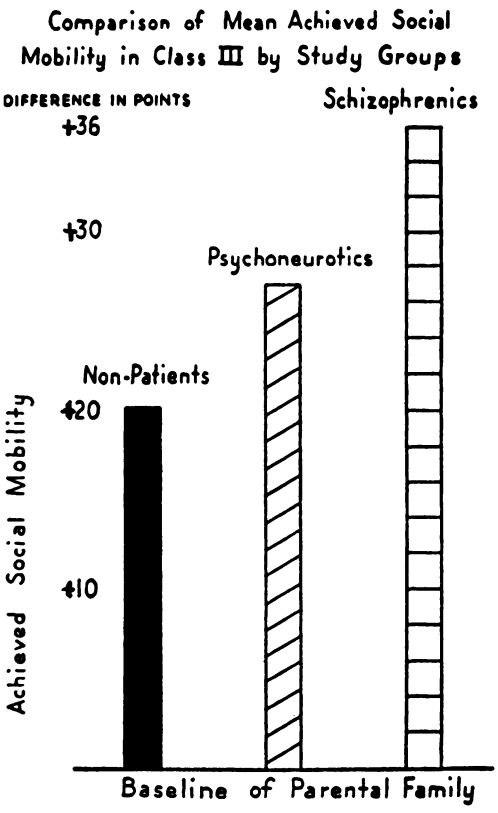

FIG. 1

schizophrenics, were "overachievers" in comparison with their brothers and sisters.

Achieved Social Mobility in Class V.—The mobility pattern for the class V nonpatients, psychoneurotics, and schizophrenics summarized in Fig. 2 is very different from that of class III. The nonpatients in class V moved, on the average, only 8 points up the mobility Index. The schizophrenics also moved upward 8 points, but the psychoneurotics made a 12 point gain. This was significantly more than the nonpatients achieved. When the mobility of the class V patients was compared with that of their adult brothers and sisters no significant difference was found between the psychoneurotics and their siblings. The schizophrenics, however, had significantly lower scores than their brothers and sisters.

The significant relationship between upward mobility and psychoneurosis in class III and in class V was in accordance with the first postulate. The data on schizophrenia, on the other hand, are not clear-cut. The schizophrenics in class III achieved almost twice as much mobility as the nonpatients, but in class V they achieved no more than the nonpatients. However, the sharp differences in the mobility patterns in the 2 classes were in agreement with expectations. They reinforced the assumption that the quantity of social mobility is different from one class to another. They suggested also that individual case records needed to be studied carefully to determine the meaning the selected mobility factors had for individual psychoneurotics and schizophrenics in both classes.

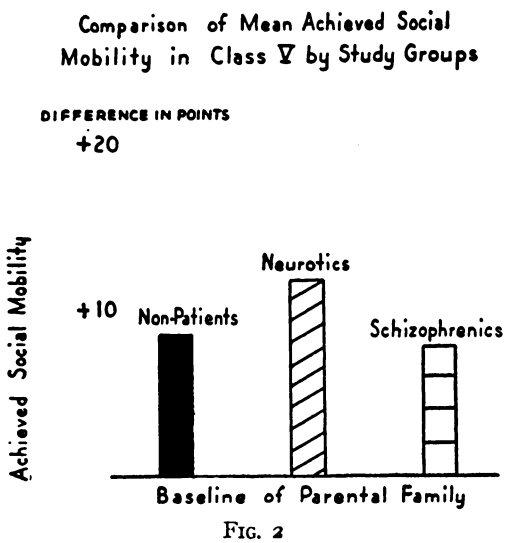

FIG. 2

Proposition Two.—The attempt to assess the meanings that these mobility factors had for the patients gave rise to the second proposition. It assumed marked discrepancies between achievement and aspiration. Achievement was defined, in accordance with proposition one, as the position a patient had attained educationally and occupationally. What he said he wanted to achieve in each area was defined as aspiration. The difference between what was attained and what was hoped for was defined as discrepancy. The discrepancy, if any, between achievement and aspiration was assumed to be a stress vector in the patient's life.

Throughout the analysis of the data on achievement and aspirations we were concerned with the question: Are the aspirations voiced by these patients expressions of their behavior or are they phantasies without any overt behavioral correlate? In order to answer this question, each patient's history was studied to determine if evidence supported his statements of his aspirations. If his premorbid behavior indicated he had made more or less consistent efforts to bridge the gap between his claimed aspirations and his actual achievements, it was inferred that verbalized statements of his hopes were characteristic of his behavior.

Educational Discrepancies—Class III.—The data on educational achievement, aspiration, and discrepancies in class III are summarized in Table 2. This tabulation shows that the average class III psychoneurotic completed slightly more than 1 year of college, but he aspired to a college degree. The average class III schizophrenic completed

TABLE 2

MEAN EDUCATIONAL ACHIEVEMENT AND ASPIRATIONS MEASURED IN YEARS OF SCHOOL FOR CLASS III PSYCHONEUROTICS AND SCHIZOPHRENICS

	Years of School	
Educational	Psychoneurotics	Schizophrenics
Achievements	13.3	14.1
Aspiration	16.1	16.4
Discrepancy	2.8	2.3
	$F=8.688, 1/25$	$F=6.988, 1/25$
	$p<.01$	$p<.05$

2 years of college, and he, too, wanted to finish college. The discrepancy between educational achievement and aspiration among the class III psychoneurotics and schizophrenics is significant. These patients worked hard to achieve their educational goals. Moreover, they viewed education as the one area of activity that would enable them to realize their goals in life. As a consequence, they blamed their failures upon either their lack of education or the limited educational opportunities open to them during their childhood and adolescent years.

The class III schizophrenics emphasized education more strongly than the psychoneurotics; and they implemented their desires by going to school a year longer. Every schizophrenic had put forth great personal effort to obtain his education. They were usually good students and they enjoyed school. Typically their problem was to get enough education to prepare for the job they wanted. They worked upon the premise that if they could get enough education they would get the desired job, then they would be accepted socially, and their problems would be ended. Finally, they looked upon education as a panacea for their personal and social problems. Unfortunately, their educational strivings were usually without encouragement or guidance from their parents.

Class V.—Educational achievements and aspirations among the class V patients are summarized in Table 3, which shows that the discrepancy between achievement and aspiration is significant for both the psychoneurotics and the schizophrenics.

The class V psychoneurotics believed they could have had skilled jobs or clerical "positions" if only they had been able to finish high school and had received specialized vocational training. They stated their aspirations largely in terms of a better job, and they looked retrospectively to education to solve their economic problems. The function of education, as they looked back upon it, was to prepare an individual for a good job. A good job meant a higher standard of living, and, if one lived well, what other problems could one have?

TABLE 3

MEAN EDUCATIONAL ACHIEVEMENT AND ASPIRATIONS MEASURED IN YEARS OF SCHOOL FOR CLASS V PSYCHONEUROTICS AND SCHIZOPHRENICS

	Years of School	
Educational	Psychoneurotics	Schizophrenics
Achievement	8.9	7.3
Aspiration	13.8	10.6
Discrepancy	4.8	3.3
	$F=14.158, 1/23$	$F=6.462, 1/23$
	$p<.01$	$p<.05$

The class V schizophrenics all encountered educational frustrations. Most of them were compelled to leave elementary school, after the eighth grade, by a combination of economic circumstances and parental indifference, if not hostility, toward education. As adults, they regret their lack of an education, and they are aware that they cannot improve their positions without more education, but they feel incapable of obtaining it.

Occupational Discrepancies—Class III.—When we turn from the educational to the occupational area, we find a definite discrepancy between the actual and the idealized in both classes and diagnostic groups. However, there are no essential differences in the occupations engaged in by the class III psychoneurotics in comparison with the class III schizophrenics. Both groups have moved in the course of their lives from manual work into work that requires specialized training and reasonably smooth interpersonal relations. The men are employed as clerks, salesmen, and supervisors; the women are employed, or they were before marriage, as secretaries, elementary teachers, nurses, and technicians. Although the occupational achievements of both sexes have been substantial, their aspirations are far above their accomplishments. The men would like to be professionals or in business for themselves; the women would prefer to be professionals, or married to professional men. The occupational reference groups of the patients include lawyers, doctors, professors, engineers, artists, musicians, and business executives. Only two class III patients were satisfied occupationally; one was a psychoneurotic and the other was a schizophrenic; both were females.

Class V.—The class V patients, both psychoneurotics and schizophrenics, were either semiskilled or unskilled workers. They felt their jobs were unsatisfactory; they worried about how long they would last, the nature

of the work, that they did not pay enough to meet the needs of their families, that there was no advancement, and that the job carried no status.

The jobs they aspired to included: nurse, teacher, veterinarian, engineer, master mechanic. Not a single class V patient realized his aspirations in the economic area. As a group, they were aware of the connection between "good" jobs, "steady" jobs, jobs that paid a "living wage," and a dreamed-of standard of living. Occupational aspirations were particularly strong among the women. Apparently they visualized the connection between education, jobs, and mobility better than the men. This may be the reason why they were more frustrated in their verbalizations of their hopes than the men. About one-half of the men hoped for a steady, semiskilled factory job; the remainder dreamed of skilled jobs. Their wives, however, wanted more money, shorter hours, and higher status jobs for their husbands.

Discussion

Our data demonstrate that neurotic and schizophrenic patients are more upwardly mobile than the average population. They show stronger upward mobility than their parents and siblings. Considering that the more severe forms of neurosis and schizophrenia are crippling diseases and seriously impair man's efficiency, such upward mobility and its concomitant achievement in occupation and education are interesting and even surprising. These data are further proof that the downward drift hypothesis of schizophrenia is not correct(6, 7). It seems that neurotics and schizophrenics, at least prior to the onset of illness, are achievers and possibly overachievers.

Not all schizophrenics and neurotics are upwardly mobile. In our case material a few patients were hardly mobile; one schizophrenic patient and one neurotic were downwardly mobile. In our clinical experience we have encountered other cases of downward social mobility. While upward mobility seems to be the rule, downward mobility occurs. This fact in itself demonstrates that mobility features are not essential and necessary concomitants of mental illness but rather phenomena which vary according to social and psychological characteristics of the specific case. Based on clinical observations, we found downward mobility to be a rare but serious concomitant of neurosis. It occurs particularly in the self-destructive character neuroses, as they were dynamically described by Karl Menninger(9). We have noticed it in chronic alcoholism and other drug addictions, in various forms of antisocial behavior, and in chronic invalidism.

While actual upward mobility in our patient population is definite and marked, mobility aspirations in both the schizophrenic and neurotic population are even more striking. The discrepancies between achievement and aspirations in the individual patient as well as in our total diagnostic groups are interesting quantitative indices of the patients' lack of ego strength and their subsequent flights into phantasy. We have used occupation and education as indices denoting achieved and aspired mobility. Mobility can be most clearly discerned in these spheres; but other spheres did not escape our attention. In the females in our series of patients we were impressed by the use of physical attractiveness, charm, and sex in the broad sense to achieve mobility. Such strivings often centered around the effective choice of a mate for marriage. When ineffective it resulted in various socially disapproved forms of sexual behavior, ranging from the behavior of the lonely and frustrated spinster who either avoided or rejected men to the more flagrant forms of antisocial behavior, such as promiscuity or prostitution. Frustration and conflict over frustrated mobility aspirations may be discerned in all these spheres.

Our material has led us to some questions about the nature and genesis of social mobility. American culture, generally speaking, prescribes upward mobility; but how does the individual learn to be mobile? What accounts for the various forms of mobility? What are the underlying identifications with parents and siblings or the rejection of such persons and their ego ideals which might explain various forms of social mobility? Such problems will be dealt with in further publications.

There is one more problem we would like to touch upon. In previous work(14) we

demonstrated that patients of the upper classes more frequently receive psychotherapy, particularly insight therapy, than patients of the lower classes who receive supportive psychotherapy and organic treatments more frequently. We assume that these differences can be explained, not only by economic conditions, but by differences in attitudes, values, and belief systems between middle-class therapists and their patients(13). To participate in insight therapy patients must understand, to a certain extent at least, what the therapist is driving at and share some of his basic convictions, motivations, and values, such as the strong motivation to think and act rationally and to fulfill one's own potential and help others to fulfill theirs. Although very few lower-class patients receive insight therapy we felt the need to explain how such exceptional patients are capable of participation in such therapy. Our clinical experiences indicate that such lower class patients are socially upwardly mobile individuals, who aspire to have values similar to those of the therapist. In contrast to such upwardly mobile patients who are often good therapeutic risks, the downwardly mobile patient—usually a self-destructive, self-punitive, moral masochistic person—is likely to show negative therapeutic reactions. We wish to stress that while social mobility does not explain the etiology or treatability of mental illness, it can, when properly understood—as one of many factors —help us to arrive at a better understanding of the complex and puzzling conditions we have to recognize, treat, and understand.

Summary

1. The hypothesis that social mobility is related to psychoneurosis and schizophrenia was tested as part of a large study on social class and psychiatric disorders in the metropolitan New Haven community.

2. Methods in studying the social mobility of 25 psychoneurotics and 25 schizophrenics divided between social classes III and V and a number of control subjects are described.

3. These psychoneurotics and schizophrenics are more mobile than the control subjects.

4. There is a discrepancy between achieved and aspired mobility in the psychiatric patients.

5. The implications of the above findings for phenomenology, etiology, and treatment of psychoneurosis and schizophrenia are discussed.

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